DATA ON POSTPARTUM MOOD DISORDERS

A REPORT TO THE
RHODE ISLAND GENERAL ASSEMBLY

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BACKGROUND

POSTPARTUM MOOD DISORDERS

On June 27, 2001, the Rhode Island House of Representatives enacted a Resolution directing the RI Department of Health to establish a panel to research, compile and synthesize data relating to postpartum mood disorders and to present a report to the General Assembly.

In response to this resolution, HEALTH contacted the following individuals for national and local information and data on postpartum mood disorders:

Jay Buechner, Ph.D., Office of Health Statistics, HEALTH
Jorge Garcia, MPH, Health Policy Analyst, HEALTH
William Hollinshead, MD, Family Health Medical Director, HEALTH
Jane Honikman, Founding Director, Postpartum Support International
Margaret Howard, Ph.D., Day Hospital Director, Women and Infant's Hospital
Sam Viner-Brown,MS, Kids Net, HEALTH
Teri Pearlstein, MD, Academic Division Director, Women and Infant's Hospital
Karen Rosene-Montella, MD, Chief of Medicine, Women and Infant's Hospital

INTRODUCTION

As many as 80 percent of women may experience a mood disorder during the postpartum period. The postpartum blues is the most common of these disorders, followed by postpartum depression, and lastly the rarely occurring postpartum psychosis. Postpartum mood disorders are caused by a combination of biological factors (genetics and the precipitous drop in estrogen levels following childbirth) and psychosocial factors, ranging from lack of sleep to the stress from work and family responsibilities and the roles and expectations of women.

The children of mothers who suffer from serious postpartum mood disorders are at an elevated risk for developmental delays as well as behavioral and learning problems. In addition, mothers who have depression may become less involved in their children's lives. The children tend to grow up having difficulties forming personal relationships and interacting with peers.

Although treatment is effective, many women do not receive adequate treatment for postpartum mood disorders. Some women may suffer in silence, as they feel ashamed or embarrassed about the feelings and thoughts that they are having. Other women may not be taken seriously when these symptoms occur or are disregarded as being "hormonal." Postpartum mood disorders are real conditions with real symptoms that, when left untreated, may have detrimental consequences for the mother, the child and the entire family.

Postpartum Blues

Between 50 and 80 percent of all new mothers will experience postpartum blues. The onset of postpartum blues usually occurs during the first 3 - 5 days after delivery, and normally lasts for two weeks. This period may be characterized by difficulty sleeping, eating, and concentrating, as well as crying spells and irritability. Approximately 1 out of every 5 women with postpartum blues will develop postpartum depression.

The good news is that there is effective treatment for postpartum mood disorders. The postpartum blues tends to last less than two weeks and the symptoms are relatively mild. These symptoms usually pass quickly when the mother receives emotional support and assistance with caring for the newborn.

Postpartum Depression

About 13 -15 percent of women develop postpartum depression anytime within the first four weeks after childbirth and up to a year after. The incidence of postpartum depression is even greater among adolescent mothers, for whom the rate is over 20 percent. The symptoms of postpartum depression are just like the symptoms of major depression. These include, fatigue, difficulty concentrating, sense of guilt or worthlessness, insomnia, and recurring thoughts of death and suicide. In addition, mothers may experience severe anxiety as well as lack of interest in her baby.

One of the most important risk factors for postpartum depression is having had a depression episode in the past. In fact, more than fifty percent of women with a history

of depression will become depressed again after childbirth. Other significant risk factors include a family history of mood disorders, low socio-economic status and being single.

Depending on the severity of the symptoms, treatment for postpartum depression ranges from skilled psychotherapy (interpersonal therapy and cognitive-behavioral therapy) to a combination of anti-depressants with counseling. There are a number of effective medications. Many experts recommend serotonin reuptake inhibitors (SSRIs), as there are no known short-term adverse effects in newborns of breastfeeding mothers who take several of the SSRIs. The right medication must be determined on a case-by-case basis.

Postpartum Psychosis

Postpartum psychosis is the most severe of the postpartum mood disorders affecting 1 to 2 women per one thousand births. The major symptoms associated with this disorder are agitation, confusion, hallucinations, delusions and paranoia. Women with a prior history of postpartum mood episodes are at an elevated risk for postpartum psychosis. Infanticide is commonly linked to this disorder, as the mother may experience command hallucinations to kill the baby, or delusions that the baby is possessed.

For the treatment of postpartum psychosis the recommended treatment guideline includes a combination of an antidepressant with an antipsychotic drug. Again, there are safe choices for breast-feeding mothers. In severe cases (suicidal and psychotic thoughts), the mother may require hospitalization while her symptoms are managed. This will ensure her wellbeing and that of the baby.

LOCAL DATA

Hospitalizations for Postpartum Mental Disorders, Rhode Island, 1998-2000

The hospital discharge data files include all discharges from private, acute-care hospitals in Rhode Island during the three-year period October 1, 1997 – September 30, 2000 (hospital fiscal years 1998-2000).

There were 50 discharges of women diagnosed with postpartum mood disorders during this period, for an average of approximately 17 cases per year. Of the 50 cases, four were diagnosed during the hospital stay for delivery; the remaining 46 were diagnosed during a subsequent hospitalization.

During this period, there were a total of 38,995 births in these hospitals (average of 12,998 per year), so that there were an average of 1.3 hospitalizations for postpartum mood disorders per 1,000 deliveries per year. The distribution by (hospital fiscal) year was as follows: 1998, 13 (26%); 1999, 18 (36%); 2000, 19 (38%).

Of the women hospitalized, 12 (24%) were between 15-24 years of age and 10 (20%) were between 35-44 years. The largest concentration of women hospitalized was in the 25-34 years age group, with 28 (56%) of all hospitalizations.

The diagnosis codes used to identify cases of postpartum mood disorders does not include information on the mother's specific disorder. Of the 50 discharges, 45 (90%) had one or more additional diagnosis code(s) for a specific mental disorder; the total of 66 such codes was distributed as follows: Organic psychotic conditions, 2 (3%); other

psychoses, 15 (23%); and neurotic disorders, personality disorders, and other nonpsychotic mood disorders, 49 (74%) [This group includes most types of depression.]

RESEARCH

The National Institute of Mental Health is the leading federal program supporting research around mental health issues affecting women, including research around postpartum mood disorders. Two of such funded studies focus on ethnic minority women who are pregnant or had recently delivered. One is testing an adaptation of cognitive-behavior therapy to reduce symptoms of prevention and prevent ante and postpartum depression among Hispanic women. The other one looks at cognitive-behavior therapy as a preventive tool, and also includes improving parenting skills in African American and Hispanic women. At Women and Infants Hospital, Dr. Caron Zlotnick has received funding from the NIMH to develop an interpersonal-oriented intervention that targets those factors that may play a significant role in the development of postpartum depression (i.e., poor social support, role transitions, and life stressors). Dr. Zlotnick's research is entitled " Depression Intervention for Poor Pregnant Women."
Other areas being studied include bipolar relapse prevention; the interaction between estrogen antidepressants and serotonin levels; the association between stress and reproductive hormone levels and depression. In addition, validation and comparison studies for depression screening instruments are taking place at various centers, including the University of Connecticut.

Research is also taking place in the pediatric arena. In Rhode Island, the Fetal Behavior Program, at the Infant Development Center, is studying fetal development in high-risk populations, particularly pregnant women with a major depressive disorder. This is one of the first studies to examine the effects of maternal antidepressant use and depressive disorders on fetal and newborn neurobehavioral development. The Infant Development Center is a collaboration between Bradley Hospital and Women and Infants Hospital. The Center is part of the Department of Pediatrics at Women and Infants Hospital, and the Department of Psychiatry and Human Behavior and the Department of Pediatrics of the Brown Medical School.

LOCAL INITIATIVES

<u>Rhode Island Pregnancy Risk Assessment Monitoring System</u>

The Pregnancy Risk Assessment Monitoring System (PRAMS) is part of the Centers for Disease Control and Prevention (CDC) initiative developed in 1987, to reduce infant mortality and low birth weight. PRAMS is an ongoing, state-specific, population-based surveillance system designed to identify and monitor selected maternal behaviors and experiences before, during, and after pregnancy among stratified samples of mothers who have recently given birth to a live infant. RI is instituting this national surveillance model in January 2002, while maintaining its active risk assessment program to identify mothers and babies at risk of poor outcomes. Women and/or babies identified to be at risk are referred to the appropriate services.

The global goal of PRAMS is to reduce infant morbidity and mortality by providing surveillance data to guide programs influencing maternal behaviors during and immediately after pregnancy. Every month, a systematic stratified sample of 160 new Rhode Island mothers will be selected from birth certificates and a questionnaire will be sent within 2 - 4 months after delivery. The questionnaire is comprehensive and contains

topics, such as attitudes and feelings about the pregnancy, prenatal care, nutrition, and psychosocial support and stress, among others. The RI system will commence with babies born January 1, 2002 and it is anticipated that the questionnaires will be mailed in April 2002.

Day Hospital Program

The Day Hospital at Women and Infants is the only specialized treatment program for pregnant or postpartum women with depression, obsessive compulsive, or anxiety disorders. It is the first Day Hospital program in the nation to allow mothers and newborns to stay together. Since the program started in 2000, more than 380 women have been enrolled, most of them for treatment of a postpartum disorder. Being housed at the hospital where the majority of births in the state take place, the Day Hospital is at an advantageous position to reach out to a large group of women at risk. A multidisciplinary team of clinicians staffs the program, and its services are reimbursable through most health insurers.

OBSERVATIONS

Treatment for postpartum mood disorders may be given in various settings, including private medical practices and community mental health centers, among others. However, a comprehensive and coordinated system that ensures access and quality care must be clearly defined and maintained.

Although research on the causes and treatment of postpartum mood disorders has increased during the last decade, more research is still warranted, particularly around evaluation of prevention and treatment programs. Research among the pediatric population affected by postpartum mood disorders must continue to be developed.

Questionnaires that detect signs of postpartum depression should be made available to women upon discharge from the hospital, at obstetricians' offices and at pediatricians' offices. Health insurers can easily identify new mothers and send them a complimentary screening survey and a list of available resources. There are two self-administered questionnaires that are valid for screening for signs of postpartum depression: the Edinburgh Postnatal Depression Scale and the Postpartum Depression Screening Scale.

The Day Hospital Program distributes postpartum mood disorders educational material to all mothers who give birth at Women and Infants and other nearby hospitals. Educational materials should be offered at all birthing centers in RI as well as health care facilities that see the new mothers after birth.

A public education campaign may help remove the stigma associated with postpartum mood disorders. The campaign should focus on removing the stigma that is associated with mental illness as well as changing the perception that these are "hormonal" disorders. Mental health advocacy organizations are well-experienced in conducting anti-stigma campaigns for other mental illnesses.

The Maternal Depression Roundtable of the Women's Mental Health Consortium (NIMH) recommends that pediatric well child check-ups, early child care centers and other like programs are ideal places to identify and reach out to women with young children who

may be planning subsequent pregnancies, for prevention and treatment efforts.

In 1999, Congressman Jack Kingston from Georgia, submitted a resolution with respect to postpartum depression to the House of Representatives (106th Congress). Among the recommendations of this resolution are:

- Encourage obstetricians to inquire prenatally about any psychiatric problems and screen for on-going depression.
- Training of appropriate health care professionals in screening for postpartum mood in order to increased the chances of early detection.
- Include fathers and other family members in the education and treatment of the mothers.

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